# INFORMATION

## You Can Help Medical Education Pay Its Own Way

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AMERICA'S MEDICAL SCHOOLS are in serious financial trouble. The reasons are apparent: (1) enrollments have increased sharply, (2) medical education costs have skyrocketed, (3) income has lagged, and (4) some of the best faculty members are being lured away from teaching and research by better salary offers elsewhere.

The situation would be much worse if it were not for an abundant shower of gifts from philanthropic foundations, federal and state governments, business and industry, and generous individuals. Such gifts range all the way from the Ford Foundation's splendid donation of $90,000,000 last year in support of privately endowed medical schools to a crumpled envelope containing two $1 bills and an anonymous note, "For cancer research," received by a West Coast university.

But a curious fact was noted in the 1956 annual report of the National Fund for Medical Education: While contributions from corporations and foundations increased substantially, *contributions from individual physicians decreased.*

Why should this be? Members of the medical profession are more keenly aware of the plight of our medical schools than anyone else.

In my position I have examined many gifts for educational purposes. I have talked to numerous individuals desiring to contribute funds in ways that would accomplish the most good.

In my opinion the average physician is not as aware of the legal techniques of philanthropy as is the average businessman or corporation. In other words, he is uncertain of what steps to take to aid medical education and at the same time obtain substantial tax benefits.

In this article, therefore, I propose to outline a few of the more important ways in which physicians can contribute to medical schools and at the same time realize substantial tax savings.

The medical profession can also help in another important way. Physicians are sometimes asked for suggestions by patients who wish to aid medical education. If the physician knows the several ways in which gifts can be made, he is in a much better position to assist his patients.

But first, let us examine in more detail the present crisis in medical education and the reasons behind it. America's 82 great medical schools today teach 29,000 medical students, graduating more than 6,800 annually. They train 11,500 graduate physicians, residents and interns, and give refresher courses to 21,500 physicians. They instruct 19,000 dental, pharmaceutical and nursing students—plus 8,000 nonmedical students. They annually provide 2,300,000 persons with medical care (valued at $115,000,000). And finally, they furnish leadership and counsel for hundreds of health agencies.

But with a national population growth of more than 2,500,000 persons annually—a net gain of 7,000 a day—America's medical schools are being called upon to supply a larger number of professional health experts and a greater volume of medical care than ever before.

From 1910, when Dr. Abraham Flexner's famous report led to the overhauling of America's medical schools, medical education has been in an ever-challenging period of transition. Although we have forged to world leadership in medicine, our financial resources in support of it have not kept pace. In most cases a medical school will consume from 30 to 40 per cent of the parent university's income—yet enroll only about 10 per cent of the students.

According to the Association of American Medical Colleges, the estimated medial expense of a medical student is $2,178 per year in privately supported schools and $1,160 (resident) to $1,930 (nonresident) at tax-supported schools. More scholarships are badly needed so that medicine, as a career, will not be denied to any worthy young man or woman of great talent but modest means.

No other form of education is as expensive as medical education with its longer period of training, high ratio of teachers to students, new and complicated teaching techniques. Medical education is four to five times as expensive as general university education—a factor in keeping medical school salaries low. Because of this glaring fact, many of our most competent teaching and research men are being lost to industry, government and private practice.

Obviously, more money is needed to maintain medical education at its present level. Federal subsidy has been suggested, but experience has demonstrated that this method could effect controls over teaching programs and professional practices that might be detrimental to the good of the nation.

While President of Columbia University in 1949, and recognizing that "medical education is a national problem which should be met on a national basis," Dwight D. Eisenhower said:

"The financial problems of the medical schools

should be solved through private, rather than governmental, means. Excessive reliance on government violates the essential principle of our free enterprise system."

Business and industry are recognizing their obligations in maintaining America's health programs. But it is the physicians of America who must give more generously—as they give of their time and counsel in the tradition of Hippocrates—to train tomorrow's physicians.

Gifts to educational institutions are encouraged by both federal and state governments. In 1954 Congress increased such maximum allowable tax deductions from a previous 20 per cent to 30 per cent of adjusted gross income. The purpose of this increase was to provide additional funds to educational institutions in view of their rising costs and the relatively low rate of return received on endowment funds.

What are some of the ways by which physicians or their patients can accomplish the greatest good for the support of our nation's medical schools and at the same time realize maximum tax reductions themselves?

Briefly, here are a few of the many methods that have come to my attention during the past year that may be of most interest:

#### CASH GIFTS

The simplest way for you, as a physician, to make a gift to a medical school or a foundation is by a cash gift. However, you should be careful in making your charitable contributions to stay within 30 per cent of your adjusted gross income.

To illustrate, suppose you are unmarried and have a taxable income of $25,000 (after all deductions except the deduction for charitable contributions and before the personal exemption). You wish to make a gift of $7,500 to a college for its medical school. Ordinarily without the charitable deduction, you would pay a federal income tax of $9,796 on your earnings. With the gift of $7,500 you reduce the tax to $5,650. Therefore, the actual net cost of the $7,500 gift is $3,354.

Or let us suppose you are a married taxpayer filing a joint return with itemized deductions (other than educational, charitable and religious) of 10 per cent of adjusted gross income, and have an adjusted gross income of $75,000. Almost two-thirds of the cost of the maximum deductible gift of $22,500 to a medical school is borne by the Federal Government! The net cost of the $22,500 gift to you is only $8,733. Of course, because of graduated income tax rates, the savings are less for those of smaller income. However, if our hypothetical taxpayer has an adjusted gross income of $50,000, in this situation, the Treasury Department would in effect pay for more than half of the maximum deductible gift of $15,000. The net cost thereof to the donor would be but $7,110. And if we assume an adjusted gross income of $25,000 under otherwise similar circumstances, the maximum gift of $7,500 would actually cost the donor just over $5,000.

#### SHORT TERM TRUSTS

The short term trust is a device that has proved to be especially advantageous for physicians. Since the inclusion of this statutory exemption in the tax revision of 1954, many physicians have already established short-term educational trusts. Let me explain how this technique is used.

Let us imagine that you are a physician in your fifties in a relatively high income tax bracket at present, but foresee retirement or a later period in which your income will be lower. The use of the short-term educational trust is ideally suited for a person in such circumstances.

With the use of this method, you irrevocably convey assets in trust for a period of at least two years, but for a longer term if you wish, with instructions to pay the income to a particular university for its medical school, and at the end of the prescribed time to return the principal to yourself or your estate.

The advantage of such a trust is that for the years of the trust its income is excluded from your income but you have not parted with the principal permanently. Therefore, top-bracket income of small net worth is temporarily released; at the same time, the underlying assets are preserved for your or your family's later use.

The following situation will clarify this principle: Let us say you are a single person with a net taxable income of $75,000 and tax liability of $46,170. You establish a trust to exist for three years with property having an annual income of $10,000. For each year of your gift your income is reduced by $10,000 and your tax liability is lessened by $7,950. Thus, at the end of three years you have made a $30,000 gift at an actual cost to you of $6,150.

#### APPRECIATED PROPERTY

The savings that may be gained by giving appreciated property are great. If you have property (other than inventoriable items or assets held for ordinary business sale) which has increased in value, it is much to your advantage to make a gift of the property itself rather than to sell it and then to donate the proceeds. By giving the property, you can deduct its full present value, subject to the 20 per cent or 30 per cent limitation rules. However, you are not liable for any capital gains tax.

This can be made clearer by considering an example. Let us suppose you have a net taxable income

of $25,000 (after all deductions except the deduction for charitable contributions and before the personal exemption) and wish to give securities at present worth $7,500 that you obtained for $2,500 more than six months before. If you sell the stock, you would realize a long-term capital gain of $5,000 on which there would be a $1,250 capital gains tax. Thus, you have an actual net value in the securities of $7,500 less $1,250 or $6,250. If you were to give the $6,250 to a college for its medical school, your income would be reduced by approximately $3,516. Therefore, the school receives a $6,250 gift at an actual cost to you of slightly more than $2,730. However, if you give the stock to the medical school, you do not pay the capital gains tax and can deduct the full $7,500 as a charitable deduction. This deduction cuts your tax by $4,146. That amount plus the avoidance of the $1,250 capital gains tax reduces the actual cost of the gift of $7,500 to less than $2,105. And, remember, the medical school is benefited by the full $7,500.

In cases where the physician is in a higher tax bracket this technique of giving appreciated property to a medical school may be more advantageous to him in a financial sense than selling the same property and keeping the proceeds. To illustrate, let us assume that a physician, who is single, has an adjusted gross income of $150,000 and owns securities with a current market value of $50,000 which he acquired more than six months ago for $10,000. If he gives the stock to a medical school, he will ultimately end up with $4,500 more than he would have been able to retain had he sold it and kept the proceeds.

Conversely, if the property has depreciated in value and is of a kind on the sale of which one may legitimately claim a tax loss, it is more advantageous to sell it and then turn the proceeds over to the foundation or medical school in order to gain the maximum tax savings.

#### TESTAMENTARY GIFTS

Ordinarily it is more advantageous for tax purposes for a donor to make a living gift than to make a gift by will. Oliver Wendell Holmes humorously expressed such a thought when he wrote:

"Learn to give
Money to colleges while you live.
Don't be silly and think you'll try
To bother the colleges, when you die,
With codicil this, and codicil that,
That knowledge may starve while the Law grows fat;
For never was pitcher that wouldn't spill,
And there's always a flaw in a donkey's will."

However, death tax advantages are substantial for a physician who includes medical schools or foundations in his will.

The estate tax deduction for charitable gifts reduces the actual cost of donations. This amount comes off the top of the estate, eliminating it from the impact of the highest rate of taxation.

To illustrate, let us assume that upon your death you have a taxable estate of $200,000 and have provided for a $25,000 bequest to a medical school. The federal estate tax would be reduced by $7,500. This means that the actual cost to your estate of the $25,000 gift is $17,500. Naturally the tax savings are greater in larger estates.

Of course, the types of gifts that I have mentioned are just a very few of the many techniques that might be used. And there are innumerable possible variations of each, depending on your individual wishes and circumstances. Perhaps a testamentary trust might be best for you or a gift by life insurance, or maybe you should consider giving by will certain real property that would be difficult to sell for appraised value, in order to eliminate it from your taxable estate. Your tax adviser can assist you in making the proper choice.

The tax savings referred to above are savings in federal taxes only. Contributions to medical schools are also deductible for California income tax purposes subject to prescribed statutory limitations and likewise are deductible under the California Inheritance Tax Law.

Here is one suggestion that I cannot emphasize too strongly: *When investigating the form which the benefaction should take, or in drafting the proper instrument of conveyance, by all means consult an attorney, a tax expert or an officer of the medical school or foundation of your choice.*

How much are American physicians now giving toward medical education? In 1956 a total of more than $3,000,000 was given in two ways: (1) approximately $2,000,000 was given by physicians directly to the nation's 82 medical schools, and (2) another $1,000,000 was contributed through the American Medical Education Foundation. Until last year, the A.M.E.F. channeled its funds through the National Fund for Medical Education (a business and industry fund-raising organization). In the future, however, the A.M.E.F. will make its own distribution of funds.

It has been variously estimated that the additional income needed annually by our medical schools is from $10,000,000 to $40,000,000.

Your individual contribution will help medical education pay its own way and yield rich dividends in better health and new victories over disease. All Americans have a stake in the future of medical education—but you, as a physician, have the greatest stake of all.

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# Medical Professional Liability

**The following special report by the law department of the American Medical Association on medical professional liability was approved by the Board of Trustees and transmitted to the A.M.A. House of Delegates at the 1957 annual meeting for its information. The board also voted that the recommendations made by the law department be approved and implemented.**

**The report was referred to Reference Committee on Insurance and Medical Service, which approved the recommendations; and the Reference Committee's report then was adopted by the House.**

### SPECIAL REPORT OF THE LAW DEPARTMENT

#### Introduction

AT ITS MEETING in December, 1954, the Board of Trustees requested the law department to review previous actions of the American Medical Association with respect to medical professional liability and to plan and initiate any necessary additional studies. This action by the board was taken in response to a number of resolutions presented to the House of Delegates by state medical societies requesting advice and assistance in this field. After consultation with the staff of the Council on Medical Service and the Committee on Professional Liability of the Committee on Medicolegal Problems, it was determined that further investigation and study was necessary and desirable.

It was recognized at the outset that two approaches to the study were available. We could say as little as possible about the subject for fear of stimulating additional claims or we could plan a program designed to educate the members of the profession concerning accident and claims prevention and alert them to the pitfalls and occupational hazards in the practice of medicine. It was and is our belief that only by facing up to the facts of the past and present concerning medical professional liability can the profession intelligently plan ways and means to cope with this problem in the future.

Since the initiation of its study, the law department has submitted three progress reports to the Board of Trustees: one in May, 1955, one in November, 1955, and the most recent in May, 1956. This report is intended to summarize the most significant results of our study up to the present time.

For approximately two years, facts, figures, and opinions have been collected. This material has been reviewed, studied, and analyzed. It is hoped that the results will add to existing knowledge in the field and will provide the basis for workable and effective professional liability claims prevention programs.

Because of some of the conclusions and recommendations contained in this report it has been identified as "confidential." It is a matter for the board's discretion as to whether all or parts of it should be released.

#### Scope of the Study

The following projects have been completed and the results have been published in the *Journal.*

(a) *State Regulations.* A questionnaire was prepared jointly with the Council on Medical Service and sent to each state insurance commissioner for the purpose of obtaining authoritative information regarding the regulation and control of professional liability insurance rates.

(b) *Survey of State Medical Societies.* A questionnaire was sent to all of the state medical societies and the medical societies of the District of Columbia, Hawaii, and Alaska to obtain the opinion of society officials concerning such subjects as: The average amount of coverage and the availability of professional liability insurance, the most prevalent problems in the field, and the status of claims prevention programs.

(c) *State Statutes of Limitation.* A detailed study has been made of the statutes of limitation of each state relating to medical professional liability.

(d) *Analysis of Reported Cases.* A review has been made of medical professional liability court cases on which official reports have been published from 1935 through 1955. The analysis of these reported cases indicates the geographic areas in which professional liability cases occur most frequently, the types of medical procedures involved, the circumstances which caused the suits to be filed, and their disposition.

(e) *Government Physicians.* An analysis has been made of professional liability claims involving physicians in all branches of federal government service.

(f) *Survey of National Medical Societies.* A questionnaire inquiring as to available group insurance programs or other similar arrangements was sent to and completed by 13 national medical societies.

(g) *Opinion Survey of Physicians.* A questionnaire was sent to approximately 7,500 members of the American Medical Association, representing a random sample of about 5 per cent of the membership. Of these questionnaires 71.2 per cent or 5,341 were completed and returned. Opinions were requested on various aspects of medical professional liability and inquiry was made as to whether a professional liability claim has ever been brought against them. A second questionnaire requesting detailed information was sent to those physicians who indicated that a professional liability claim or suit had been brought against them.

(h) *Special Articles.* The preparation and publi-

cation of a series of articles on various aspects of medical professional liability, entitled: The History of Professional Liability Suits in the United States; Expressing Opinions as to Former Treatments; Put It in Writing, Doctor; Medicolegal Hazards of Anesthesia; Hazardous Fields of Medicine in Relation to Professional Liability; Res Ipsa Loquitur—Liability Without Fault; Rule of Respondeat Superior; Professional Liability Insurance: Amount of Coverage; and Professional Liability Claims Prevention.

The above categories of inquiry form the basis for this report. In conducting this study our hypothesis has been that most professional liability claims can be prevented if knowledge of the causes of past claims is put to intelligent use. The information we have obtained, thus far, confirms this belief. Although we have not exhausted all possible sources of information we have learned a great deal about professional liability and the causes of claims.

### The Law of Professional Liability

Although this report is primarily concerned with the legal duty of the physician to avoid injury to his patient we also of necessity have given some consideration to the physician's ethical, moral, and social responsibilities in the practice of medicine. Generally, the fulfillment of these responsibilities will serve to satisfy the obligations which the law imposes upon the physician.

It is a general rule of law that a physician must possess that degree of medical knowledge and skill possessed by other physicians in his or a similar community engaged in a similar type of practice. He must also use his best judgment and reasonable and ordinary care in applying his knowledge and skill to the treatment of patients. The specialist or the man who holds himself out to the public as a specialist is required to possess and exercise that degree of care and skill commonly possessed by those engaged in the same specialty, in the same or similar community.

### The Nature of the Problem

Patients who have sustained an unsatisfactory result and are aware that they have not received the *best* possible medical care are potential claimants. Where there is a poor medical result, merely fulfilling legal standards of care is sometimes not enough to prevent a claim. This usually is the case when the patient believes that the physician is not sufficiently sympathetic or if he considers the physician's fees to be excessive.

Professional liability cannot therefore be properly regarded as a legal problem exclusively. It is also a medical problem and one which in our opinion requires the same intensive study that the profession has devoted to the conquering of disease. The legal problems associated with medical professional liability can be dealt with adequately only if medicine will provide the type of emphasis to accident prevention and the utilization of already acquired knowledge as it does to scientific advancement. When effective means are discovered for reducing or minimizing medical professional liability problems it will be physicians who will lead the way by devising techniques that will minimize medical mistakes and patient dissatisfactions.

### Availability of Professional Liability Insurance and Amount of Coverage

Without exception, all of the organizational representatives who replied to our medical society questionnaire indicated that medical professional liability insurance was available to the physicians in their state. Furthermore, all of them, except two, stated that it is not difficult to obtain. One indicated that physicians in certain specialties had difficulty, and another said that difficulties had been encountered by physicians who had a previous claim or suit brought against them.

In the survey of individual physicians, 92.3 per cent said that they carried professional liability insurance and 92.6 per cent said that the insurance was not difficult to obtain. Of those answering the questionnaire 56.4 per cent expressed the opinion that the cost of professional liability insurance is reasonable.

The limits of professional liability coverage appears to vary widely even within a state and within the different types of practice. According to the information supplied by medical society representatives the average (median) coverage across the country for general practitioners is $25,000 for one claim and $75,000 for all claims during the year; for surgeons and other specialists $100,000 and $300,000. There are at least 45 carriers writing medical professional liability insurance in the United States.

### Effect of Professional Liability Claims on Physician's Reputation

A substantial majority of medical society representatives reported that in their opinion professional liability claims have little or no effect on the reputation and on the practice of the physician involved. A few medical society spokesmen explained that in the smaller communities in their area the effects of such claims and suits are more pronounced than in larger communities. Other responses indicated that the effects were greater when newspaper publicity was given to the case. A few responses explained that the effects were more adverse if the physician had previously been the subject of a professional liability claim or suit.

### Incidence of Professional Liability Claims

Many medical society executives and individual physicians have, on numerous occasions in the past, expressed concern over what they describe as an "alarming" increase in the frequency of professional liability claims. It is unfortunate that insurance company records are either unavailable or inaccessible to determine the actual trend. Realizing that the individual physician may not be in a position to supply authoritative information as to whether there is, in fact, a rapid rise in the frequency of claims in his community, in the absence of more accurate data, we nevertheless feel that their opinions deserve consideration. According to our survey of physicians, only 29.7 per cent of the respondents to the question on this point were of the opinion that there has been an increase during the past five years. Of the respondents, 39.7 per cent felt that the incidence of claims had not increased. The remainder thought that claims had decreased or else they had no opinion.

In California, Louisiana, New York, Rhode Island, Utah, the District of Columbia, and Hawaii, there was a clear-cut expression of opinion that professional liability claims have increased in frequency during the past five years. For example, 59.7 per cent of the California physicians said that in their opinion there has been an increase.

### Validity of Claims

Our study of reported court decisions and the survey of physicians who stated that a claim had been brought against them indicates that approximately 50 per cent of the claims and suits could not be sustained legally. There were, however, a considerable number of instances reported in which a claim was brought against a qualified physician which involved either actual negligence in treatment or a substantial basis on which a patient could reasonably believe he suffered from the negligence of a physician. In a few instances it appeared that the claims were either fraudulent or so wholly lacking in foundation as to compel the inference that the patient was acting in bad faith.

Many physicians consider the problems of professional liability as a matter of academic interest. The fact is that professional liability claims are *not* limited to a small group of "malpractice prone" doctors. Among the physicians who indicated that they had experienced claims, 86.5 per cent incurred only one claim in their entire professional practice. Only 10.5 per cent of the physicians who reported claims had two claims in their entire professional practice; 1.9 per cent, three claims; and 1.1 per cent, four claims. Our figures indicate that professional liability is the problem of the many, not the few.

In a number of cases which were resolved in favor of the physician because of technical legal grounds it is possible that the verdict would have been against the defendant had the case been decided on its medical merits. On the other hand, there was a significant number of cases involving the doctrine of "res ipsa loquitur" (the thing speaks for itself) wherein the courts assumed negligence solely because there was no medical explanation for an unsatisfactory result.

### Professional Liability Claims Review Committees

The executives of thirty-one state medical societies indicated that a claims review program has been established in their state either on a state or county level. The usual procedure followed by these committees is this: When a claim is reported, the physician involved is called in to meet with the committee. The committee attempts to determine whether the claim is legitimate and whether there is evidence of actual professional liability. If the physician has been careless or unethical or has undertaken procedures beyond his competence, he and the insurance carrier are advised to settle the case. If the negligence of the physician is not apparent every legitimate effort is made to encourage or assist in the defense of the case.

We feel that these committees can render a real service to the public and the profession by indirectly improving the quality of patient care, and in the discouragement of invalid or nuisance claims. Such committees should not attempt to usurp the function of courts in the adjudication of claims nor interfere in the normal relationship between the physician and his insurance carrier.

### Professional Liability Claims Prevention Programs

Although only 21 state medical societies reported that they have a claims prevention program, 73.9 per cent of the physicians polled believe that such programs perform a valuable function. Of the physician respondents, 23.7 per cent said that a claims prevention program is now offered by their *county* medical society. Of this number, 76.1 per cent rated their county program as either adequate or excellent.

It appears from these figures and from the fact that 76.3 per cent of the physicians reported the absence of claims prevention programs in their county medical society that there is a nationwide need and a desire on the part of the medical profession to stimulate the initiation of such programs.

If properly planned and implemented such programs have a twofold objective: The prevention of medical accidents which lead to claims and the prevention of unwarranted claims—in brief, the improvement of medical service.

**Claims Statistics**

The following are some of the significant statistics concerning professional liability claims as shown by our survey of physicians:

(a) 14.1 per cent or approximately 1 out of every 7 physicians responding to our questionnaire experienced professional liability claims during his professional medical career.

(b) 53.7 per cent of those who have had *claims* said that the claims were brought against them since 1950.

(c) 43 per cent said that the *alleged act* of malpractice occurred since 1950.

(d) Thirty-four years was the approximate median age of patient bringing the claim.

(e) 55 per cent of the claimants were female, but 10 states had more male than female claimants, and 6 states had about the same number of female and male claimants.

(f) 72.5 per cent of the physician respondents who had claims reported that they had personally performed the treatment or act of alleged malpractice.

(g) 67.2 per cent of the incidents of alleged malpractice occurred in hospitals, 23.9 per cent in the physician's office, 6.3 per cent in the home of patient, and the remaining 2.6 per cent occurred elsewhere in such places as factories, or the place of the incident was not stated by the respondent.

(h) 30.9 per cent of the claims involved surgery, 20.0 per cent medicine, 19.7 per cent orthopedics, 12.5 per cent obstetrics and gynecology, 6.2 per cent neuropsychiatry, 5.6 per cent anesthesiology, and the remaining 1.1 per cent were either too small to tabulate separately or were not stated by the respondent.

(i) The physicians who had 93.2 per cent of the claims reported that they had professional liability insurance at the time of the alleged incident.

(j) 28.9 per cent of the physicians against whom claims were brought are certified by an American specialty board.

(k) 50.4 per cent of the physicians against whom claims were brought stated that they were full-time specialists.

(l) Physicians experiencing claims said that they were in practice, on the average (median), about 13 years before they had a claim.

**Conclusions**

After studying the problems of medical professional liability for the past two years our basic conclusion is that most claims are preventable and not inevitable. We feel that our analysis of professional liability cases and claims and the surveys we have conducted warrant the following specific conclusions:

(a) An element which is present in all professional liability claims is dissatisfaction arising out of the physician-patient relations. Many of the cases which actually involved substandard medical treatment would probably not have matured into claims had it not been for some other cause of friction between the patient and the physician.

(b) Professional liability, although varying in severity in different localities, is a national problem which transcends local boundaries. To be effective, a professional liability claims prevention program requires leadership at the national as well as the state and local levels.

(c) The objective of the medical profession is not the prevention of professional liability claims as such, but the prevention of avoidable errors and omissions that result in injury to the patient and stimulate litigation, and the discouragement of unfounded claims. To implement this objective there is need for (1) an intensive educational program which emphasizes the nonmedical as well as the medical causes for professional liability claim, and (2) the utilization of the self-disciplining resources of the medical profession in the prevention of medical accidents within and outside the hospital.

(d) Regardless of the safety measures that are taken, the ever-increasing complexities of modern medicine create possibilities for human errors and omission even among the most qualified and experienced practitioners.

(e) In the interest of the public as well as the profession, physicians who have demonstrated that they are careless, incompetent or unethical in the treatment of patients should be dealt with effectively through medical society, state licensure and hospital disciplines to prevent the recurrence of patient injury.

(f) An effective educational and accident prevention program should include not only physicians, but physicians' employees and the hospital personnel for whose acts the physician may be responsible.

(g) An effective prevention program should include periodic examinations of equipment to avoid mechanical failures, and the abandonment of obsolete and defective devices.

**Recommendations**

(a) Considering that more than 2 out of 3 of the incidents resulting in professional liability claims occur in hospitals, patient tort liability is now a matter of common interest and mutual concern between the medical profession and hospitals. It is suggested that the Board of Trustees consider the advisability

of entering into discussions with representatives of the American Hospital Association with the objective of formulating and implementing an effective in-hospital safety and accident prevention program.

(b) We recommend that this report be called to the attention of the American Medical Association's representative on the Joint Commission on the Accreditation of Hospitals for their consideration as to the feasibility of encouraging that organization's interest in the subject herein presented.

(c) That state and county medical societies be urged by the Board of Trustees and the House of Delegates to create or, if in existence, implement more effectively, Claims Prevention Programs. To facilitate the efforts of the state societies in this project the law department is forwarding to each state executive secretary all statistics pertaining to his state which have been collected during the course of the current survey.

(d) That state and county medical societies be encouraged to show the film on Medical Professional Liability prevention and to plan informational and educational programs on this subject at state and county meetings.

(e) That the Board of Trustees authorize the printing and distribution of the compilation of medicolegal forms and explanatory text material which has been developed by the law department.

(f) That the law department be authorized to conduct the second phase of the professional liability survey consisting of an opinion survey of selected attorneys and the judiciary, an analysis of available information concerning insurance experience and a survey of comparable fields of negligence actions.

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**For Your Patients—**

## *Certainly, let's talk about fees...*

In this day and age I think we all are faced with many similar financial problems. Though our incomes may be derived from different sources, our expenditures, for the most part, consist of food, clothing, shelter and other expenses including medical care.

As your personal physician, you realize my income is solely from my fees; fees which I believe to be entirely reasonable. However, should you ever have any financial worries, I am most sincere when I say that *I invite you to discuss frankly with me any questions regarding my services or my fees. The best medical care is based on a friendly, mutual understanding between doctor and patient.*

You've probably noticed that I have a plaque in my office which carries this identical message *to all my patients.* I mean it—

*Sincerely,*

_____, M.D.

**MESSAGE NO 3.** Attractive, postcard-size leaflets, you to fill in signature. Available in any quantity, at no charge as another service to CMA members. Please order by Message Number from CMA, PR Department, 450 Sutter, San Francisco. (If you do not have the plaque mentioned in copy, let us know and it will be mailed to you.)